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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DEBRA MARIE SPENCER aka DEBRA SPENCER** 240 Spruce Street, Apt #2 Arroyo Grande, CA 93420 **Registered Nurse License No. 607199** Respondent.	Case No. 2010 - 291 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On September 27, 2002, the Board of Registered Nursing, Department of Consumer Affairs issued Registered Nurse License No. 607199 to Debra Marie Spencer ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2010, unless renewed.

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing, ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

3. Section 2761 of the Code states, in part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

COST RECOVERY

4. Section 125.3, subdivision (a), states, in part:

> Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department . . . the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Discipline by Washington State Board of Nursing)

5. Respondent has subjected her license to disciplinary action under section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that on or about August 15, 2006, pursuant to an Order made by the Washington State Board of Nursing ("Washington RN Board"), *In the Matter of the license to practice as a registered nurse, docket No. 06-04-A-1012RN, Debra Marie Spencer*, which is attached hereto as Exhibit A, the Washington RN Board indefinitely suspended Respondent's ability to practice as a professional nurse in the State of Washington. The reasons for the above captioned disciplinary proceedings were based upon

the following actions by Respondent; On or about December 17, 2004 through February 4, 2005, while Respondent was employed as an emergency room registered nurse at St. Joseph Medical Center in Tacoma, Washington (Hospital), Respondent diverted the controlled substances Percocet (oxycodone), Vicodin (hydrocodone), and Dilaudid (hydromorphine) from the hospital for her own personal, non-therapeutic use.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing, Department of Consumer Affairs issue a decision:

1. Revoking, suspending or placing on probation, Registered Nurse License No. 607199, issued to Respondent Debra Marie Spencer;

2. Ordering Respondent Debra Marie Spencer to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/15/09

Louise R. Bailey

LOUISE R. BAILEY, M.Ed., ~~R.N~~
Interim Executive Officer
Board of Registered Nursing
State of California
Complainant

60496371.wpd

EXHIBIT A

Arizona State Board of Nursing, Order No. 0511114

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Debra Marie Spencer
Docket No.: 06-04-A-1012RN
Document: Statement of Charges

Regarding your request for information about the above-named practitioner, certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

If you have any questions or need additional information regarding the information that was withheld, please contact:

> Customer Service Center
> P.O. Box 47865
> Olympia, WA 98504-7865
> Phone: (360) 236-4700
> Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Deputy Secretary, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

I certify that this is a true and correct copy of the document on file with the State of Washington, Department of Health, Adudicative Clerk Office

Aaron Kelley
Signature

8/11/2009
Date

FILED

JUN 22 2006

Adjudicative Clerk Office

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Registered Nurse of: **DEBRA MARIE SPENCER** License No. RN00117651 Respondent	**Docket No. 06-04-A-1012RN** **STATEMENT OF CHARGES**

The Health Services Consultant, on designation by the Nursing Care Quality Assurance Commission (Commission), makes the allegations below, which are supported by the evidence contained in program file number 2005-02-0045RN. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

Section 1: ALLEGED FACTS

1.1 Debra Marie Spencer, Respondent, was issued a license to practice as a registered nurse by the state of Washington in July 1994. Respondent's license expired on June 8, 2005, but is subject to renewal.

1.2 On or about December 17, 2004 through February 4, 2005, while employed as an emergency room registered nurse at St. Joseph Medical Center in Tacoma, Washington (Hospital), Respondent diverted the controlled substances Percocet (oxycodone), Vicodin (hydrocodone), and Dilaudid (hydromorphone) from the Hospital for her own personal, non-therapeutic use, as evidenced by following medication discrepancies.

1.3 On December 17, 2004, Respondent withdrew two (2) Percocet tablets from the PYXIS machine for Patient A but failed to administer the Percocets to Patient A and /or document administration of the medication in Patient A's medication administration record (MAR).

1.4 On December 17, 2004, Respondent withdrew two (2) Percocet tablets from the PYXIS machine for Patient B, documented administration of one (1) Percocet to Patient B, but failed to waste the remaining one (1) Percocet.

1.5 On December 19, 2004, Respondent withdrew one (1) Vicodin tablet from the PYXIS machine for Patient C but failed to administer the Vicodin to Patient C and/or document administration of the medication on Patient C's MAR.

1.6 On December 23, 2004, Respondent withdrew two (2) Percocet tablets from the PYXIS machine for Patient D but failed to administer the Percocets to Patient D and/or document administration of the medication on Patient D's MAR.

1.7 On December 26, 2004, Respondent withdrew a Vicodin ER Pak (4 tablets given to a patient at time of discharge) from the PYXIS for Patient E but failed to distribute the Vicodin ER Pak to Patient E and/or document distribution of the medication in Patient E's MAR.

1.8 On January 3, 2005, Respondent withdrew 2 mg of Dilaudid from the PYXIS machine for Patient F, documented administration of 1 mg of Dilaudid in Patient F's MAR, but failed to waste the remaining 1 mg of Dilaudid.

1.9 On January 9, 2005, Respondent withdrew a Percocet ER Pak from the PYXIS for Patient G but failed to distribute the ER Pak and/or document distribution of the ER Pak in Patient G's MAR.

1.10 On February 2, 2005, Respondent withdrew two (2) Percocet tablets from the PYXIS for Patient H but failed to administer the medication to Patient H and/or document administration of the medication in Patient H's MAR.

1.11 On February 3, 2005, Respondent withdrew 2 mg of Dilaudid from the PYXIS for Patient J, documented administration of 1 mg of Dilaudid to Patient J, and failed to waste the remaining 1 mg of Dilaudid.

1.12 On February 3, 2005, Respondent withdrew four (4) Percocet ER Paks for Patient J, distributed one (1) ER Pak to Patient J, but failed to waste the remaining three (3) Percocet ER Paks.

1.13 On February 3, 2005, Respondent withdrew 2 mg Dilaudid from the PYXIS for Patient K but failed to administer the Dilaudid to Patient K and/or document administration of the medication in Patient K's MAR. Further, there was no physician's order for Patient K to receive Dilaudid.

1.14 On February 4, 2005, Respondent withdrew one (1) Vicodin tablet from the PYXIS for Patient L but failed to administer the Vicodin and/or document

administration of the medication in Patient L's MAR. Further, Patient L did not have a physician's order for Vicodin.

1.15 On June 20, 2005, the Department of Health investigator sent a letter of allegations to the Respondent. Respondent failed to respond in writing to the letter of allegations.

Section 2: ALLEGED VIOLATIONS

2.1 Based on the facts in Section 1, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (6), (7), (8)(b) and/or WAC 246-840-710(2)(c), (e), which provide in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
>
> (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
>
> ***
>
> (6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;
>
> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
>
> (8) Failure to cooperate with the disciplining authority by:

***

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

***

WAC 246-840-710. Violations of standards of nursing conduct or practice. The following conduct may subject a nurse to disciplinary action under the Uniform Disciplinary Act, chapter 18.130 RCW:

***

(2) Failure to adhere to the standards enumerated in WAC 246-840-700 which may include, but are not limited to:

***

(c) Willfully or repeatedly failing to make entries, altering entries, destroying entries, making incorrect or illegible entries and/or making false entries in employer or employee records or client records pertaining to the giving of medication, treatments, or other nursing care;

***

(e) Willfully or repeatedly failing to follow the policy and procedure for the wastage of medications where the nurse is employed or working;

***

2.2 The above violation provides grounds for imposing sanctions under RCW 18.130.160.

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Section 3: NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare. The Health Services Consultant of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline pursuant to RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

DATED: June 22, 2006.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE
COMMISSION

Mary Dale
MARY DALE
HEALTH SERVICES CONSULTANT

Oscar Chaves, WSBA # 34951
ASSISTANT ATTORNEY GENERAL

FOR INTERNAL USE ONLY: **PROGRAM NO. 2005-02-00045RN**

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named herein. RCW 42.17.310(1)(d)

Patient A

Patient B

Patient C

Patient D

Patient E

Patient F

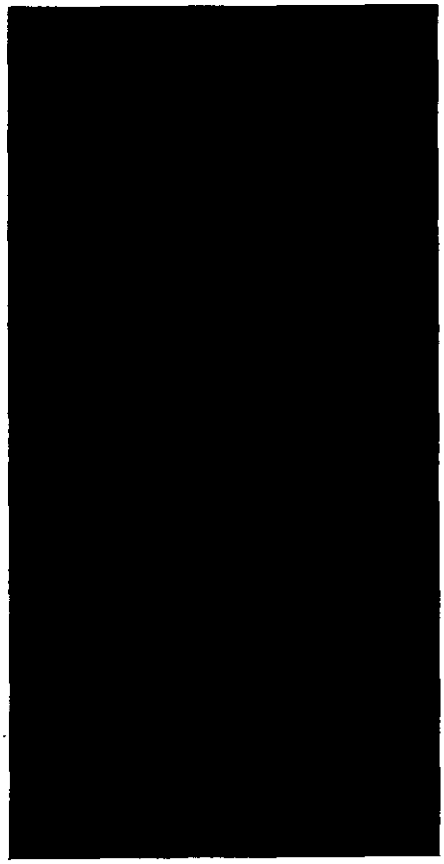
Patient G

Patient H

Patient J

Patient K

Patient L



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Debra Marie Spencer
Docket No.: 06-04-A-1012RN
Document: Final Order of Default

Regarding your request for information about the above-named practitioner, certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld: **NONE**

If you have any questions or need additional information regarding the information that was withheld, please contact:

Customer Service Center
P.O. Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4700
Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Deputy Secretary, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

I certify that this is a true and correct copy of the document on file with the State of Washington, Department of Health, Adudicative Clerk Office

Aaron Kelley
Signature

8/11/2009
Date

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Registered Nurse of **DEBRA MARIE SPENCER** License No. RN00117651 Respondent	**Docket No. 06-04-A-1012RN** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER OF DEFAULT (Failure to Respond)**

This matter comes before the Health Law Judge, Presiding Officer for final order of default. Based on the record, the Presiding Officer, on designation by the Nursing Care Quality Assurance Commission (Commission), now issues the following:

Section 1: FINDINGS OF FACT

1.1 Debra Marie Spencer, Respondent, was issued a license to practice as a registered nurse by the state of Washington in July 1994. Respondent's license expired on June 8, 2005, but is subject to renewal.

1.2 On or about December 17, 2004 through February 4, 2005, while employed as an emergency room registered nurse at St. Joseph Medical Center in Tacoma, Washington (Hospital), Respondent diverted the controlled substances Percocet (oxycodone), Vicodin (hydrocodone), and Dilaudid (hydromorphone) from the Hospital for her own personal, non-therapeutic use, as evidenced by following medication discrepancies.

1.3 On December 17, 2004, Respondent withdrew two (2) Percocet tablets from the PYXIS machine for Patient A but failed to administer the Percocets to Patient A and /or document administration of the medication in Patient A's medication administration record (MAR).

1.4 On December 17, 2004, Respondent withdrew two (2) Percocet tablets from the PYXIS machine for Patient B, documented administration of one (1) Percocet to Patient B, but failed to waste the remaining one (1) Percocet.

1.5 On December 19, 2004, Respondent withdrew one (1) Vicodin tablet from the PYXIS machine for Patient C but failed to administer the Vicodin to Patient C and/or document administration of the medication on Patient C's MAR.

1.6 On December 23, 2004, Respondent withdrew two (2) Percocet tablets from the PYXIS machine for Patient D but failed to administer the Percocets to Patient D and/or document administration of the medication on Patient D's MAR.

1.7 On December 26, 2004, Respondent withdrew a Vicodin ER Pak (4 tablets given to a patient at time of discharge) from the PYXIS for Patient E but failed to distribute the Vicodin ER Pak to Patient E and/or document distribution of the medication in Patient E's MAR.

1.8 On January 3, 2005, Respondent withdrew 2 mg of Dilaudid from the PYXIS machine for Patient F, documented administration of 1 mg of Dilaudid in Patient F's MAR, but failed to waste the remaining 1 mg of Dilaudid.

1.9 On January 9, 2005, Respondent withdrew a Percocet ER Pak from the PYXIS for Patient G but failed to distribute the ER Pak and/or document distribution of the ER Pak in Patient G's MAR.

1.10 On February 2, 2005, Respondent withdrew two (2) Percocet tablets from the PYXIS for Patient H but failed to administer the medication to Patient H and/or document administration of the medication in Patient H's MAR.

1.11 On February 3, 2005, Respondent withdrew 2 mg of Dilaudid from the PYXIS for Patient J, documented administration of 1 mg of Dilaudid to Patient J, and failed to waste the remaining 1 mg of Dilaudid.

1.12 On February 3, 2005, Respondent withdrew four (4) Percocet ER Paks for Patient J, distributed one (1) ER Pak to Patient J, but failed to waste the remaining three (3) Percocet ER Paks.

1.13 On February 3, 2005, Respondent withdrew 2 mg Dilaudid from the PYXIS for Patient K but failed to administer the Dilaudid to Patient K and/or document administration of the medication in Patient K's MAR. Further, there was no physician's order for Patient K to receive Dilaudid.

1.14 On February 4, 2005, Respondent withdrew one (1) Vicodin tablet from the PYXIS for Patient L but failed to administer the Vicodin and/or document

administration of the medication in Patient L's MAR. Further, Patient L did not have a physician's order for Vicodin.

1.15 On June 20, 2005, the Department of Health investigator sent a letter of allegations to the Respondent. Respondent failed to respond in writing to the letter of allegations.

1.16 The Department has filed the Declaration of Mary Dale, Health Services Consultant, with attached exhibits.

1.17 On June 22, 2006, the Commission served Respondent with a copy of the following documents at Respondent's last known address:

A. Statement of Charges;

B. Notice of Opportunity for Settlement and Hearing;

C. Answer to Statement of Charges and Request for Settlement and Hearing;

D. Stipulated Findings of Fact, Conclusions of Law, and Agreed Order.

1.18 To date, the Adjudicative Service Unit has not received an answer to the Statement of Charges. On July 19, 2006, the Adjudicative Service Unit issued a Notice of Failure to Respond.

1.19 The Commission has no reason to believe Respondent is now or was in active military service, or a dependent of a person in active military service at the time the Statement of Charges was served.

Section 2: CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over Respondent and over the subject matter of this case. RCW 18.130.040.

2.2 Respondent did not file a response to the Statement of Charges within the time allowed. WAC 246-11-270(1)(a)(i) or WAC 246-11-270(3). Respondent is in default and the Commission may issue a final order based on the evidence presented, RCW 18.130.090(1) and RCW 34.05.440.

2.3 Based upon the Findings of Fact, Respondent has engaged in unprofessional conduct in violation of RCW 18.130.180(1), (6), (7), (8)(b) and/or WAC 246-840-710(2)(c), and (e).

2.4 Sufficient grounds exist to take disciplinary action against Respondent's license. RCW 18.130.160 and 18.130.180.

Section 3: ORDER

The COMMISSION ORDERS:

3.1 The license to practice as a registered nurse in the state of Washington held by Debra Marie Spencer shall be and is hereby INDEFINITELY SUSPENDED with no right to seek modification of this Order and/or reinstatement of licensure for a period of at least twenty-four (24) months from the date of entry of this Order.

3.2 Respondent shall present both portions of her license to the Department of Health, Nursing Commission within ten (10) days of receipt of this Order.

3.3 Prior to petitioning for modification and/or reinstatement of her license, Respondent must provide satisfactory evidence of being clean and sober for at least twenty-four (24) consecutive months immediately preceding any such petition. Evidence of being clean and sober shall include, but is not limited to, *observed* biological fluid testing, completion of chemical dependency treatment, participation in professional peer support groups and NA/AA, and a recent (within 90 days) chemical dependency evaluation by a commission – approved evaluator. The evaluation shall include:

A. Respondent's condition or diagnosis;

B. Conclusions and prognosis;

C. Recommendations regarding the need for ongoing care and treatment;

D. Professional opinion regarding Respondent's ability to practice nursing with reasonable skill and safety.

3.4 Respondent may submit a written request for modification no sooner than twenty-four (24) months from the date of entry of this Order and/or reinstatement of her license no sooner than twenty-four (24) months from the date of entry of this Order. Respondent must at that time be prepared to provide proof of satisfactory compliance with the terms and conditions imposed in this Order. Respondent must personally appear before the Commission at any such hearing, however, at the discretion of a

Reviewing Commission Member, the terms and conditions of this Order may be modified through an Agreed Order, or Respondent's license reinstated without a hearing. Upon notice and an opportunity for Respondent to be heard, the Commission may impose additional conditions after reviewing the documents submitted and reviewing Respondent's compliance with this Order.

3.5 Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

3.6 Respondent is responsible for all costs of complying with this Order.

3.7 Respondent shall inform the Commission and the Adjudicative Service Unit, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change.

3.8 The effective date of this Order is the date the Adjudicative Service Unit places the signed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Order.

Section 4: NOTICE TO PARTIES

This Order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, 45 CFR Part 61, and any other applicable interstate/national reporting requirements. If adverse action is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either Party may file a **petition for reconsideration,** RCW 34.05.461(3); 34.05.470. The petition must be filed within ten (10) days of service of this Order with:

Adjudicative Service Unit
PO Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

State of Washington
Department of Health
Nursing Care Quality Assurance Commission
PO Box 47864
Olympia WA 98504-7864

The petition must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied twenty (20) days after the petition is filed if the Adjudicative Service Unit has not

responded to the petition or served written notice of the date by which action will be taken on the petition.

A petition for judicial review must be filed and served within thirty (30) days after service of this Order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, however, the thirty (30) day period will begin to run upon the resolution of that petition, RCW 34.05.470(3).

The Order remains in effect even if a petition for reconsideration or petition for review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit, RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail, RCW 34.05.010(19).

DATED: August 15th, 2006.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE
COMMISSION

HEALTH LAW JUDGE
PRESIDING OFFICER

Presented by:

JANET STAIGER, WSBA #16573
DEPARTMENT OF HEALTH STAFF ATTORNEY

8/11/06
DATE

FOR INTERNAL USE ONLY: PROGRAM NO. 2005-02-0045RN